

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

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CONT 0 1
REPORT SOURCE L 6 0 5 0 0 0 3 4 6 7 0 9 1 5 8 1 8 1 1 0 6 8 1 9
60 61 DOCKET NUMBER 62 63 EVENT DATE 64 65 REPORT DATE 66

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

7 8 9

SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP SUBCODE VALVE SUBCODE

S F 11 D 12 Z 13 Z Z Z Z Z 14 Z 15 Z 16

9 10 11 12 13 14 15 16 17 18 19 20

REVISION

1 | (1) LES RO REPORT NUMBER [EVENT YEAR] [3] [1] [21] [22] [23] [24] [25] [26] [27] [28] [29] [30] [31] [32] NO. 1

ACTION TAKEN [G] [18] [19] FUTURE ACTION [H] [20] EFFECT ON PLANT [Z] [21] SHUT DOWN METHOD [Z] [22] HOURS [23] [24] [25] [26] [27] [28] [29] [30] [31] [32] ATTACHMENT SUBMITTED [Y] [23] [24] [25] [26] [27] [28] [29] [30] [31] [32] NPRO-4 FORM SUB. [N] [24] [25] [26] [27] [28] [29] [30] [31] [32] PRIME COMP. SUPPLIER [Z] [25] [26] [27] [28] [29] [30] [31] [32] COMPONENT MANUFACTURER [Z] [9] [9] [9] [26] [27] [28] [29] [30] [31] [32]

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause of the event was due to administrative oversight. The ECCS room coolers are

1 1 necessary for long term equipment operability, but their support function is not

1 2 specifically addressed in the Technical Specifications. A memo was written to all

1 3 supervisor, personnel re-emphasizing operability requirements, and the need for

procedural controls to cover non-standard system configurations.

1	4											80						
7	8	9																
FACILITY STATUS			% POWER			OTHER STATUS			(30)	METHOD OF DISCOVERY			DISCOVERY DESCRIPTION			(32)		
1	1	5	E	(28)	0	9	9	(29)	NA	44	A	(31)	Resident NRC Inspector					80

ACTIVITY CONTENT
RELEASED OF RELEASE AMOUNT OF ACTIVITY (35) LOCATION OF RELEASE (36)

1 6 Z (33) Z (34) NA NA

PERSONNEL EXPOSURES										
NUMBER			TYPE	DESCRIPTION						
1	7	0	0	0	17	Z	38	NA		

PERSONNEL INJURIES	
NUMBER	DESCRIPTION
1 8 0 0 0 40	NA

		LOSS OF OR DAMAGE TO FACILITY		(43)
		TYPE	DESCRIPTION	
1	9	Z(42)	NA	

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

PUBLICATION
ISSUED DESCRIPTION (45)
2 0 N 44 NA
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S PDR
NRC USE ONLY

DVR 81-140 NAME OF PREPARER Richard Chesko PHONE: (419) 259-5000, Ext. 316

TOLEDO EDISON COMPANY
DAVIS-BESSE NUCLEAR POWER STATION UNIT ONE
SUPPLEMENTAL INFORMATION FOR LER NP-33-81-70

DATE OF EVENT: September 15, 1981

FACILITY: Davis-Besse Unit 1

1 | IDENTIFICATION OF OCCURRENCE: Failure to provide adequate instructions to return Emergency Core Cooling System (ECCS) room air coolers to service in case of a loss of coolant accident (LOCA)

Conditions Prior to Occurrence: The unit was in Mode 1 with Power (MWT) = 2764 and Load (Gross MWE) = 915

1 | Description of Occurrence: On September 15, 1981, it was discovered by the NRC Resident Inspector that service water to both ECCS room air coolers in Room 115 was isolated due to small leaks for approximately 80 hours. The condition of both ECCS room air coolers being temporarily isolated was known, however, steps were not taken to document corrective action to be taken in the event of a LOCA.

The event is being reported under Technical Specification 6.9.1.9.c as an inadequate implementation of procedural controls which caused a reduction of the degree of redundancy provided in the reactor protection systems or engineered safety feature systems. There were no unit power reductions.

Designation of Apparent Cause of Occurrence: Instructions were not provided requiring the return to service of one or both of the ECCS room coolers in the event of a LOCA. One ECCS cooler had been previously isolated in an effort to plug leaking tubes when the second cooler developed a small leak. The second room cooler was isolated to minimize the need for processing the leakage as radwaste. The requirement for restoring the cooler in the event of a LOCA was understood, however, not properly administratively controlled.

Analysis of Occurrence: There was no danger to the health and safety of the public or to station personnel. The equipment described in Technical Specification 3.5.2 was not inoperable during this occurrence. However, this event is being reported because there was no formal procedural changes to insure that the cooler would be returned to service upon a LOCA.

Within approximately 45-60 minutes after a worst case LOCA, when ECCS suction has been transferred from the BWST to the hot containment emergency sump, additional ECCS room cooling would be required to maintain ambient temperatures less than design values.

Corrective Action: A room cooler was unisolated, and a memo was sent to all supervisory personnel reminding them of the importance of some auxiliary equipment that is not directly addressed in Technical Specifications which provide assurance of long term operability of the ECCS, and for the need for procedural controls to cover non-standard system configurations.

LER #81-057

The second ECCS room air cooler had its leaking coil replaced under Maintenance Work Order 81-3495 on October 13, 1981.

Failure Data: There have been no previous occurrences of this type.

LER #81-057